We select the letters for these pages from the rapid responses posted on bmj.com favouring those received within five days of publication of the article to which they refer. Letters are thus an early selection of rapid responses on a particular topic. Readers should consult the website for the full list of responses and any authors' replies, which usually arrive after our selection.

ASPIRIN AND COGNITIVE DECLINE

Too little, too late?

The study reported by Kang et al adds to the continuing debate about the usefulness (or lack thereof) of aspirin and non-steroidal anti-inflammatory drugs (NSAIDs) in preventing and treating cognitive decline in later life.[1] The authors acknowledge the dose of aspirin used was insufficient to test a putative anti-inflammatory mechanism of action and would therefore be likely only to detect possible benefit resulting from platelet inhibition; an additional major consideration mentioned only briefly in their discussion is that of the timing of the relation between either platelet aggregation or inflammatory mechanisms to the onset and progression of cognitive decline.

Many of the observational studies of NSAIDs reporting associations between use of these drugs and reduced rates of cognitive decline[2-4] included subjects with long periods of exposure to these drugs in mid-adult life. This is increasingly recognised as the period during which neurodegenerative processes may become established.[5] The potential of these agents for primary prevention of cognitive decline will remain unknown until we have seen the results of intervention studies involving younger adults.

Richard J Prettyman, consultant old age psychiatrist, Bennion Centre, Leicester LE3 9DZ richard.prettyman@leicspart.nhs.uk

Competing interests: None declared.

1 Kang JH, Cook N, Manson J, Buring JE, Grodstein F. Low dose aspirin and cognitive function in the women's health study cognitive cohort. *BMJ* 2007;334:987-90. (12 May.)
2 Stewart WF, Kawas C, Corrada M, Metter EJ. Risk of Alzheimer's disease and duration of NSAID use. *Neurology* 1997;48:626-32.
3 Bas A, Veld MD, Ruitenberg A, Hofman A, Launer LJ, Van Duijn CM, et al. Nonsteroidal anti-inflammatory drugs and the risk of Alzheimer's disease. *N Engl J Med* 2001;345:1515-20.
4 Jonker C, Comijs HC, Smit JH. Does aspirin or other NSAIDs reduce the risk of cognitive decline in elderly persons? Results from a population-based study. *Neurobiol Aging* 2003;24:583-8.
5 Braak E, Griffing K, Arai K, Bohl J, Bratzke H, Braak H. Neuropathology of Alzheimer's disease: what is new since A. Alzheimer? *Eur Arch Psychiatry Clin Neurosci* 1999;249(suppl 3):14-22.

PREPAREDNESS FOR PANDEMIC FLU

Global triage of resources needed

Planning for triage of scarce resources in the face of a flu pandemic is not simply an abstract moral dilemma[1]: it remains unsolved at the highest levels of international planning. Europe remains two to three years away from a state of preparedness for a flu pandemic.[2] Previous modelling has shown that a massive and focused use of antivirals and vaccines in places where flu may originate—probably developing countries—is vital to mitigating a pandemic.[3] This strategy presupposes that available limited resources will be distributed fairly in developing countries. This presumption is currently unrealistic.

A recent analysis of pandemic preparedness plans worldwide noted three goals of pharmaceutical interventions: reduction of morbidity and mortality (21 plans), continued maintenance of essential services (13 plans), and minimisation of social and economic impacts (13 plans).[4] The overarching goal for the early pandemic phases in the World Health Organization's plan is to coordinate international efforts to delay or possibly avert a pandemic. WHO seeks to identify needs and encourage international assistance to resource-poor countries. Yet, its plan contains no specific guidance on allocating the scarce resources needed to achieve the strategic objective. It just encourages countries to reduce disease burden in the initial outbreak locations.

We face the problem of triaging scarce resources when donating countries retain effective control over limited resources, recipient countries retain sovereignty over capabilities, and WHO (or another international intermediary) is responsible for setting global allocation priorities.

The global public health community must delineate epidemiological, legal, and ethical principles supporting a multilateral framework through which states, international institutions, and non-governmental organisations can allocate and administer scarce resources during global public health emergencies. A starting point could be a WHO expert consultation that analyses substantive and procedural aspects of this problem and develops the framework for effecting resource triage in global public health emergencies.

Daniel J Barnett, instructor, **Saad B Omer**, assistant scientist, Indiana University School of Law, Bloomington, IN 47405, USA dbarnett@jhsph.edu
David P Fidler, professor of law, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD 21205, USA
Ran D Balicer, researcher, Ben-Gurion University of the Negev, Ramat-Gan, Israel 52394
James G Hodge Jr, associate professor, Johns Hopkins Bloomberg School of Public Health

Competing interests: None declared.

1 Coker R. UK preparedness for pandemic influenza. *BMJ* 2007;334:965-6. (12 May.)
2 Watson R. Europe needs two or three years to prepare for pandemic flu. *BMJ* 2007;334:442. (3 March.)
3 Ferguson NM, Cummings DA, Cauchemez S, et al. Strategies for containing an emerging influenza pandemic in Southeast Asia. *Nature* 2005;437:209-14.
4 Uscher-Pines L, Omer SB, Barnett DJ, Burke TA, Balicer RD. Priority setting for pandemic influenza: an analysis of national preparedness plans. *PLoS Med* 2006;3:1721-7.

Government proposals conflict

The new draft plan published jointly by the Department of Health and the Cabinet Office does indeed strive to set out a framework for tackling pandemic flu at the local level.[1 2] The government advises: "Those who believe they are ill will be asked to stay home in voluntary isolation. Voluntary home isolation may be recommended for close contacts at early stages to contain/slow the spread" (section 3.2, p 35). Yet to ensure rapid access to antiviral medicines, it also proposes: "In England, plans should assume that a friend or relative will be available to collect the patient's antiviral treatment course from the designated distribution point on production of proof of identity and authorisation from the coordination centre" (section 9.9, p 90).

Both proposals are sensible, but they conflict: the friends and relatives who go out to collect the antiviral medicines will be the same people who should remain in voluntary isolation because of their close contact with those with possible flu. There are no easy solutions: voluntary isolation is

appropriate, yet so is collecting medicine.

Robert Kahn, coordinator, Avian Flu Action, Warrington WA5 2BJ rs_kahn@hotmail.com
John Godfrey, chairman, European Research into Consumer Affairs, London NW5 2LG

Competing interests: None declared.

1 Department of Health. Pandemic influenza: a national framework for responding to an influenza pandemic. 2007. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073168
2 Coker R. UK preparedness for pandemic influenza. *BMJ* 2007;334:965-6. (12 May.)

DEPRESSION IN PREGNANCY

Article is concerning

As the developers of the recent NICE guideline on antenatal and postnatal mental health[1] we found some aspects of the article by O'Keane and Marsh on depression during pregnancy of concern.[2] Firstly, by focusing on depression it perpetuates the myth that depression is the only important mental disorder of pregnancy and the postpartum period, when other disorders are also important, notably, anxiety disorders. Secondly, it is written from a secondary care perspective when the burden of care for women with common mental disorders during the antenatal and postnatal periods falls on primary care. Thirdly, the article and the NICE guideline are inconsistent.

The authors do not mention that for mild to moderate depression and anxiety a range of interventions such as various forms of guided self-help, and brief psychological treatments (including listening visits) are effective.[1 3 4] The risk:benefit ratio for antidepressants does not normally support their use in mild depression.[4]

Pregnant women are often reluctant to take drugs and so are unlikely to complete a course of antidepressants, but this is not acknowledged by the authors, who recommend antidepressants for women with moderate depression. In contrast, the guideline recommends that equally effective psychological therapies are to be preferred.[1] It also sets out recommendations for prompt access for pregnant women to psychological therapies.

O'Keane and Marsh say that women with an affective disorder who are planning a pregnancy should be referred to specialist psychiatric services, and that those with a history of recurrent depression or bipolar disorder should be referred to perinatal psychiatric services where these exist. Although this should be carefully considered for women with bipolar disorder or recurrent depression, referring women with any affective disorder is impractical and unnecessary, and may lead to an inappropriate use of specialist services.

Finally, O'Keane and Marsh say that women taking antidepressants should gradually stop breast feeding to reduce withdrawal phenomena in the newborn. This is not recommended as routine practice in the guideline. Difficulties for the infant may arise not just from withdrawal symptoms but also from serotonin toxicity (the symptoms are similar[5]), in which case the strategy they advise is not appropriate.

Dave Tomson, chair, NICE Antenatal and Postnatal Mental Health Guideline Development Group, National Institute for Health and Clinical Excellence (NICE). London WC1V 6NA
Rachel Burbeck, systematic reviewer, **Stephen Pilling**, director, National Collaborating Centre for Mental Health, University College London, London WC1E 7HB **s.pilling@ucl.ac.uk**
Liz McDonald, consultant perinatal psychiatrist, NICE Antenatal and Postnatal Mental Health Guideline Development Group

Competing interests: SP receives funding from NICE for the development of NICE clinical guidelines in mental health.

1 National Institute for Health and Clinical Excellence (NICE). *Antenatal and postnatal mental health: Clinical management and service guidance*. Clinical guideline No 47. London: NICE, 2007.
2 O'Keane V, Marsh MS. Depression during pregnancy. *BMJ* 2007;334:1003-5. (12 May.)
3 National Institute for Health and Clinical Excellence (NICE). *Depression: Management of depression in primary and secondary care*. Clinical guideline No 23. London: NICE, 2004.
4 National Collaborating Centre for Mental Health. *Depression: management of depression in primary and secondary care*. London: Royal College of Psychiatrists and British Psychological Society, 2005.
5 Haddad P, Pal BR, Clarke P, Wieck A, Sridhiran S. Neonatal symptoms following maternal paroxetine treatment: Serotonin toxicity or paroxetine discontinuation syndrome? *J Psychopharmacol* 2005;19:554-7.

EUTHANASIA IN NEONATES

Are we asking the right questions?

I question our current interpretation of "active" and "passive" euthanasia.[1] How exactly is extubating a child with serious pulmonary disease (which may or may not improve) different from giving him or her a lethal injection? The former action is legal, accepted practice, the latter is not.

Cases such as the above example are usually covered by a concurrent opiate infusion. This is administered under the so called doctrine of double effect. When a baby or child is taking terminal gasps or making similar movements the care team will often increase the infusion to reduce distress. Do they genuinely know the child is in distress or are they responding to the family's and perhaps their own distress? If the latter the action may well be entirely appropriate—but it is not reasonable to argue it is covered by the doctrine of double effect under which it is taken.

Furthermore, what is the effect on the morale of staff who might be involved with a practice of legalised active euthanasia? I know from my own practice that the effects on staff who deliver ongoing futile care can be destructive—so which is worse?

Decisions expected to result in the death of a patient, through act or omission, active or passive, should be confidentially registered and available for scrutiny through both research and audit. Only then will we be able to understand current practice, ensure it is safe, and move on to properly consider even more challenging issues.

Peter-Marc Fortune, consultant paediatric intensivist, Royal Manchester Children's Hospital, Manchester M27 4HA **peter-marc.fortune@manchester.ac.uk**

Competing interests: None declared.

1 Costeloe K. Euthanasia in neonates. *BMJ* 2007;334:912-3. (5 May.)

DECEIVING PATIENTS

Ends never justify means

The world has long known, and feared, the fallacy of consequentialism—claiming that ends can justify means—because ends simply cannot be predicted. We can never foresee the ultimate consequences of our actions.

In this world of increasing public scrutiny, it is beyond naivety to suggest the medical profession could espouse lying, without evoking a gross loss of trust in our profession, in our integrity or in the validity of any doctor-patient discourse, to name but a few consequences. How is the anaesthetist, busy drawing up her propofol, to weigh up all the chaotic, myriad future consequences of her lie against the benefits of relieving a few seconds' anxiety?[1]

Where will this all end? One has only to look across the former Iron Curtain, where I have taught communication skills to doctors, to witness how erosion of the absolute requirement for truthfulness leaves an irrevocable legacy of a deep and pervasive distrust of anything a doctor may say. And if doctors should willingly lie, why not other professions? Our bank manager perhaps? Our lawyer? Our politicians? Sokol's world is not one where I would choose to live.

Timothy S Hinks, academic clinical fellow, respiratory medicine, Dorset County Hospital, Dorchester DT1 2JY
thinks@doctors.org.uk

Competing interests: TSH is a patient registered with a general practitioner in the United Kingdom, with an intrinsic interest in not being deceived by the medical profession during future healthcare interventions.

1 Sokol DK. Can deceiving patients be morally acceptable? *BMJ* 2007;334:984-6. (12 May.)